Wisconsin Department of Regulation & Licensing

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Madison, WI 53708-8935
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Website: http://www.drl.state.wi.us

EMPLOYMENT VERIFICATION FORM FOR EMPLOYERS OTHER THAN HOSPITALS

MEDICAL EXAMINING BOARD

IMPORTANT: *PLEASE FORWARD THIS FORM TO ALL EMPLOYERS DURING THE LAST 5 YEARS (This form may be photocopied).*

The **State of Wisconsin** requests that you complete this form concerning the following individual:

PHYSICIAN'S NAME: _____

EMPLOYER'S NAME: _____

EMPLOYER'S ADDRESS: _____

EMPLOYER'S TELEPHONE: _____

1. What position did this physician hold when employed by you? _____

2. What were this physician's dates of employment? _____

	YES	NO
3. Did this physician leave your employ in good standing? If no, please attach explanation on a separate sheet.	☐	☐
4. Was the physician on probation, suspended or in any way sanctioned/disciplined while employed by you? If yes, please attach explanation on a separate sheet.	☐	☐
5. Was this physician granted a leave of absence while employed by you? If yes, please attach explanation on a separate sheet.	☐	☐
6. Were any restrictions or special requirements placed on this physician's activities which were not placed on all other employees holding similar positions? If yes, please attach explanation on a separate sheet.	☐	☐
7. Was this physician denied hospital privileges while employed by you? If yes, please attach explanation on a separate sheet.	☐	☐
8. Were any restrictions or special requirements placed on this physician's hospital privileges? If yes, please attach explanation on a separate sheet.	☐	☐
9. Were any formal patient or staff complaints filed against this physician? If yes, please attach explanation on a separate sheet.	☐	☐

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	YES	NO
10. Were any incident reports filed involving the professional conduct or behavior of this physician? If yes, please attach explanation on a separate sheet.	☐	☐
11. Was this physician ever subject to a non-routine monitoring while in your employ? If yes, please attach explanation on a separate sheet.	☐	☐
12. Was this physician removed from a call schedule for cause? If yes, please attach explanation on a separate sheet.	☐	☐

Print name of Employer Supplying Information _____

Signature of Employer Supplying Information _____

Date form was completed _____

PLEASE ATTACH LETTERHEAD FROM THE FACILITY WHERE THE APPLICANT WORKED OR SUPPLY SOME FORM OF IDENTIFICATION FOR INDIVIDUAL SUPPLYING INFORMATION.

Please return directly to:

Department of Regulation and Licensing
Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935